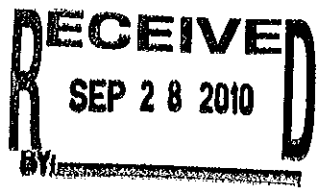
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING _____ B. WING _____	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	700 MASON HEADLEY ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted 08/24/10 through 08/26/10, and a Life Safety Code Survey was conducted 08/25/10. Deficiencies were cited with the highest Scope and Severity of an "E". ARO #KY00014847 was substantiated with no deficiencies cited. ARO KY00015214 was unsubstantiated with no deficiencies cited. ARO KY00014846 was unsubstantiated with deficiencies cited.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure care was provided in a manner which maintained each resident's dignity. Observation during meal service revealed two (2) staff members were standing while feeding residents in the dining room. The findings include: Observation in the Greenbriar dining room on 08/24/10 at 12:30 PM revealed Certified Nursing Assistant (CNA) #1 leaning on the table with one hand and feeding a resident with the other hand. Further observation revealed CNA #11 was also standing while feeding a resident. Interview with CNA #1 on 08/24/10 at 12:40 PM	F 241	F 241 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? The residents at the Greenbrair dining area were exposed to the deficient practice of promoting care in an environment that maintains and enhances each resident's dignity and respect. The CNAs were instructed promptly by the nurse manager and a chair was provided for sitting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Stavanor RN DON | TITLE: DON | (X6) DATE: 9-17-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Amendment Angela Stavanor RN DON 9-27-10

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F 241	Continued From page 1 revealed the aide was a new employee and was still in orientation. CNA #1 stated the facility had provided training related to feeding the residents, but the aide did not remember anything specific about standing and feeding. Interview with the Unit Manager (UM) on 08/24/10 at 12:50 PM revealed she had seen the two (2) aides standing over the residents while feeding. She confirmed CNA #1 was "still learning" and CNA #11 was from an outside agency. The UM provided a chair to the aide during the course of the meal. Continued interview revealed staff should have been sitting down to feed the residents.	F 241	2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. The Director of Nursing and social services made observation rounds and completed ten (10) resident interviews on 8/31/10 and 9/2/10. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? Unit Managers were in-serviced on August 26th By the Director of Nursing and all Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to standing while feeding, providing care with dignity, and promoting a respectful environment. All new hires will receive resident dignity and respectful environment training by the staff development nurse during the orientation process. 4. How will the facility monitor its performance to make sure solutions are sustained? Unit nurse mangers or designee will monitor the resident dining areas during breakfast and lunch during the weekdays and the nurse house supervisor or designee will monitor the dining areas during supper for the weekdays and during the meal times on the weekends. Unit mangers, house supervisors, or designee will monitor care delivery for dignity and providing a respectful environment (examples include by not limited to providing privacy, knocking when entering, addresses by proper names, providing matching clothing, etc) by observation of care delivery by monitoring two (2) nursing staff members every shift daily for two (2) weeks, then every shift weekly for six (6)weeks, and then every shift monthly for three (3) months. Immediate staff education will be conducted if indicated. Monitoring tools will be reviewed during the facility morning interdisciplinary team meeting. In order to maintain ongoing compliance, concerns will be reviewed in the weekly "Standards of Care" meeting. Compliance and further monitoring	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure Comprehensive Plans of Care were developed to meet the residents' medical and nursing needs for two (2) of twelve (12) sampled residents (Resident #3 and #2). The findings include: 1. Record review revealed Resident #3 had multiple admissions, the most recent being 07/29/10. Review of the Physician's Admission Orders and the Resident Admission Record revealed the resident had an allergy to Levaquin (an antibiotic). Review of the Care Plan dated, 07/14/10, prior to the most recent hospitalization, revealed Resident #3 was allergic to Synthroid, a thyroid hormone replacement drug. Further review of the Physician's Orders and the Medication Administration Record revealed Resident #3 was receiving Synthroid, fifty (50) micrograms, daily. Interview with the Minimum Data Set (MDS) Coordinator on 08/26/10 at 2:30 PM revealed she could not say why she noted Synthroid as an allergy on the Care Plan. She stated she may have confused the drug Levaquin with the generic term for Synthroid (Levothyroxine). Interview with the Director of Nursing (DON) on 08/26/10 at 3:00 PM revealed she had checked with the resident's physician and there was no documented allergy to Synthroid. Additionally, the resident had exhibited no adverse reaction to	F 279	**Completion Date 10/4/10** F 279 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? Resident #3's clinical record and comprehensive care plan was corrected with the accurate drug allergy information on August 26, 2010. Resident #2's clinical record and comprehensive care plan was corrected with the accurate safety alarm device to the wheelchair on August 24, 2010. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. Medical records audited five (5) active resident charts from each unit to compare physician orders, comprehensive care plan, and the nursing assistant care plan for accuracy by 9/23/10. Medical records completed the allergy audit on all resident charts for accuracy by 9/17/10, see #3 for specific audit.	

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F 279	Continued From page 3 daily administration of the drug. The resident was, however, allergic to Levaquin. 2. Review of Resident #2's clinical record revealed diagnoses which included Dementia and a History of a Cerebrovascular Accident (CVA). Review of the Admission Minimum Data Set (MDS) Assessment dated 08/06/10 revealed the facility assessed the resident as having both short and long term memory loss, and as requiring total assistance for transfers. Review of the Resident Assessment Protocol Summary (RAPS), dated 08/06/10 revealed the resident was non-ambulatory and relied upon a wheelchair and staff assistance for locomotive needs. Review of the Physician's Orders dated 08/10 revealed orders for a pressure alarm to the wheelchair to alert staff of unassisted transfers. Observation of Resident #2 on 08/24/10 at 11:50 AM revealed the resident was in a wheelchair in the day room; however, there was no alarm noted on the wheelchair. Observation of Resident #2 on 08/24/10 at 12:30 PM revealed the resident was in the dining room being fed by staff and there was no alarm noted on the wheelchair. Further observation of Resident #2 on 08/25/10 at 11:00 AM revealed the resident sitting in a wheelchair in the dayroom and there was no chair alarm on the wheelchair. Review of the Comprehensive Plan of Care, dated 08/24/10 revealed the resident was at risk for falls because of dependency on others for daily care needs. There were several interventions listed for fall prevention; however,	F 279	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? Safety device audits by the nurse unit managers were completed on all residents by September 17th with a comparison to the physician's orders, the comprehensive care plan, the CNA care plan, the treatment record, clinical record, and resident safety assessment. All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to safety device orders, implementation, monitoring, and care plans. Medical records completed audits for all residents for accurate resident allergy information with comparison to the condition alert sheet, face sheet, admission assessment (POS), and the care plan on September 10th and 17th with immediate corrections made if indicated. This allergy audit was added to the resident admission audit sheet which is completed by medical records next business day for all admissions and readmissions. The medical record consultant will complete a monthly report and present to the monthly CQI team consisting of administration, medical director, and Director of Nursing. All nurses will be in-serviced related to accurate documentation of allergy information on the scheduled meetings for September 17th, 18th, & 23rd. All new hire nursing staff will be in-serviced on resident safety devices, and resident allergies during the orientation process. The MDS nurse and care plan team (dietitian, therapy, social services, nursing, activities, and additional staff members as indicated) will audit the resident charts scheduled for that week's care plan meetings for comparison of physician orders, updates to the comprehensive care plans, and the nursing assistant care plans for accuracy.	

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F 279	Continued From page 4 the alarm to the wheelchair was not noted as an intervention. Interview on 08/24/10 with the MDS Coordinator revealed the Interim Care Plan was written on 07/24/10, on the resident's day of re-admission. She stated the intervention for the chair alarm was on the Interim Care Plan; however, she had failed to ensure the intervention was carried over to the Comprehensive Plan of Care. Review of the facility's, "Process for Plan of Care Development and Communication" Policy, revealed the admitting nurse would develop and initiate a written plan of care for the resident within 24 hours of admission or re-admission to include Physician's Orders and additional assessments and interventions as deemed appropriate. After the Initial Resident Assessment Instrument was completed, the Comprehensive Care Plan would be further developed and communicated to staff. The Care Plan was to be reviewed at re-admission, with a change in condition, and no less than every ninety (90) days.	F 279	4. How will the facility monitor its performance to make sure solutions are sustained? In order to monitor ongoing compliance, unit managers will maintain a safety device log with daily updates according to changes with physician orders and resident assessment changes. The log will will be reviewed at the weekly "Standards of Care" meetings. The safety device orders will be placed on the resident treatment record with a nurse check documented every shift for compliance that the device is intact and functioning appropriately. The unit managers will monitor the treatment records for compliance in nurse documentation weekly and report to "Standards of Care". Compliance will be reported by the Director of Nursing during the monthly quality assurance (CQI) meeting. These monitoring audits of safety devices and resident allergies will be ongoing tools and any findings will be addressed and any corrective actions will be initiated at that time. Medical records will audit two (2) charts from each unit monthly for compliance and accuracy in developing and updating the comprehensive	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure Physician's Orders were followed for one (1) of twelve (12) sampled residents (Resident #2).	F 281	care plans and report findings to the DON or MDS nurse promptly if a correction is needed and to the monthly CQI meetings. **Completion Date 10/4/10** F 281 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment).	

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F 281	Continued From page 5 The findings include: Review of Resident #2's medical record revealed diagnoses which included Dementia and a History of a Cerebrovascular Accident (CVA). Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/06/10 revealed the facility assessed the resident as having both short and long term memory loss, and as requiring total assistance for transfers. Review of the Physician's Orders dated 08/10 revealed Orders for a pressure alarm to the wheelchair to alert staff of unassisted transfers. Observation of Resident #2 on 08/24/10 at 11:50 AM revealed the resident was in a wheelchair in the day room and there was no alarm noted on the wheelchair. Observation of Resident #2 on 08/24/10 at 12:30 PM revealed the resident was in the dining room being fed by staff and there was no alarm noted on the wheelchair. Continued observation of Resident #2 on 08/25/10 at 11:00 AM revealed the resident was sitting in a wheelchair in the dayroom and there was no chair alarm observed on the wheelchair Interview on 08/25/10 at 11:00 AM with Certified Nursing Assistant (CNA) #5, who was assigned to the resident on 08/24/10 and 08/25/10, revealed she was hired on 07/27/10 and it was her first week being assigned to the residents by herself. She stated the aides were to refer to the "Nursing Assistants Report Sheet" when caring for the residents. She reviewed the Report Sheet and stated the intervention for a chair alarm was on the Report Sheet; however, she was unaware the resident was to have a chair alarm. Further	F 281	1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? Resident #2's clinical record and comprehensive care plan was corrected with the accurate safety alarm device applied to the wheelchair on August 24, 2010. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents with orders for safety alarm device have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. Medical records audited five (5) active resident charts from each unit to compare physician orders, comprehensive care plans, and the nursing assistant care plan for accuracy by 9/23/10. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? Safety device audits by the nurse unit managers were completed on all residents by September 17th with a comparison to the physician's orders, the comprehensive care plan, the CNA care plan, the treatment record (TAR), clinical record, and resident safety assessment. All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to safety device orders, implementation, monitoring, and care plans. Unit managers and the MDS nurses will review all new physician orders in the next scheduled morning stand up meeting to ensure transcription of order to the treatment record or medication record, update the CAN care plan, ensure implementation of the order, and update the comprehensive care plan. All physician orders will be placed on the twenty-four hour report for seventy-two hours to ensure communication between shifts with unit managers to monitor.	

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F 281	Continued From page 6 Interview, revealed she did not routinely check the Report Sheet, and only checked it if she had a question about a resident. CNA #5 observed Resident #2 in the wheelchair and confirmed the resident did not have an alarm on the wheelchair, and also stated the resident did not have an alarm on the wheelchair on 08/24/10, when she was assigned to the resident. Interview on 08/25/10 at 11:10 AM with the Unit Manager/Licensed Practical Nurse (LPN) #7, revealed she was not sure if the resident still had a Physician's Order for a chair alarm. LPN #7 reviewed the medical record, and stated there was a current Physician's Order for an alarm to the wheelchair. Further interview revealed the second and third shift nurses were to check to ensure safety devices were in place daily and sign a Safety Devices Record each day; however, she had not received the Safety Devices Record for 08/24/10.	F 281	Unit managers to monitor TARs for nursing documentation and compliance that safety devices are in use every shift and night shift charge nurse to audit safety devices every night for placement and working function. The MDS nurse and care plan team will audit The resident charts scheduled for that week's care plan meetings for the completion of physician orders, by auditing the physician orders, transcription to MARs and TARs, updates the comprehensive care plan, and the CNA care plan for accuracy. All nursing new hires will be in-serviced on resident safety devices during the orientation process.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents for one (1) of twelve	F 323	4. How will the facility monitor its performance to make sure solutions are sustained? In order to monitor ongoing compliance, unit managers will maintain a safety device log with daily updates according to changes with physician orders and resident assessment changes. The log will will be reviewed at the weekly "Standards of Care" meetings. The unit managers will monitor the treatment records for compliance in nurse documentation weekly and report to "Standards of Care". Compliance will be reported by the Director of Nursing during the monthly quality assurance (CQI) meeting. These monitoring audits of safety devices and weekly care plan audits will be ongoing tools and any findings will be addressed and any corrective actions will be initiated at that time. Medical records will audit two (2) charts from Each unit monthly for compliance and accuracy of following physician orders and report findings to the DON or MDS nurse promptly if a correction is needed and monthly to the CQI team and will continue as determined by the CQI team.	

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F 323	Continued From page 7 (12) sampled residents (Resident #2). Also, the facility failed to provide a safe environment related to items left unattained which could pose a danger to the residents. The findings include: 1. During the initial tour on 08/24/10 at 9:40 AM, observation revealed the door to a housekeeping closet on the 300 Unit was unlocked, with no housekeeping staff within sight of the door. Inside the housekeeping closet were hazardous chemicals which included Oasis 259 Glass Force, and TB Disinfectant and Deodorizer. Review of the Material Safety Data Sheet (MSDS) for Oasis 259 Glass Force revealed it may be fatal if swallowed. The MSDS for TB Disinfectant and Deodorizer revealed it was harmful if absorbed through the skin, swallowed or inhaled. Interview with Housekeeper #1 on 08/24/10 at 9:46 AM, who was around the corner cleaning an unsampled resident's room, revealed housekeeping staff were to keep the housekeeping closets locked. She stated, she was the last person to get supplies out of the unlocked housekeeping closet. Further interview revealed, after securing items from the housekeeping closet, the breakfast trolley was in the way preventing her from securing the door. Interview with the Housekeeping Supervisor on 08/25/10 at 10:25 AM revealed housekeeping doors were to be locked when not in use to ensure resident safety. Further interview revealed, sometimes the housekeeping door on the 300 Hall was unlocked due to the food trolley being in the way.	F 323	F 323 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? The housekeeping closet door on unit 3 containing hazardous chemicals was locked on August 24th and the housekeeping staff was instructed that day on safety regulations related to locked chemicals. Resident #2's clinical record and comprehensive care plan was corrected with the accurate safety alarm device applied to the wheelchair on August 24, 2010. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All mobile residents have the potential to be affected by the alleged deficient practice related to locked chemicals and all residents with orders for safety alarm devices have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. The DON and social services made observation rounds viewing locked housekeeping carts, closets, and environmental safety and interviewed five (5) employees and ten (10) residents on 8/31/10 and 9/2/10.	

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F 323	Continued From page 8 Review of the Wandering/Elopement Risk List, undated, revealed seventeen (17) residents in the facility had been assessed to be at risk for wandering. Eight (8) of the seventeen (17) residents resided on the 300 Unit. Interview with Registered Nurse (RN) #2 who had been on duty on the 300 Unit on 08/26/10 at 3:25 PM, revealed two (2) residents on the 300 Unit were at risk for wandering and had decreased safety awareness. 2. Review of Resident #2's clinical record revealed diagnoses which included Advanced Dementia and a History of Cerebrovascular Accident (CVA). Review of the Admission Minimum Data Set (MDS) Assessment dated 08/06/10 revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making, as requiring total assistance for transfers, and as being unable to ambulate. Review of the Resident Assessment Protocol Summary (RAPS), dated 08/06/10 revealed the resident was non-ambulatory, and utilized a wheelchair and staff assistance for locomotive needs. Review of the Falls Risk Assessment dated 07/24/10 revealed the resident was at moderate risk for falls related to poor safety awareness of physical abilities and limitations, incontinence of bowel and bladder, and required the assistance of one (1) to two (2) people for transfers and/or required the use of a lift device. Review of the Physician's Orders dated 08/10 revealed Orders for a pressure alarm to the	F 323	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? Housekeeping staff were in-serviced no August 1st and 16th related to safety measures regarding locked storage at all times of all hazardous chemicals if not in use by the staff and Training will be conducted with all new hires during the orientation process. Safety device audits by the nurse unit managers were completed on all residents by September 17th with a comparison to the physician's orders, the comprehensive care plan, the CNA care plan, the treatment record (TAR), clinical record, and resident safety assessment. All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to safety device orders, implementation, monitoring, and care plans. Unit managers and the MDS nurses will review all new physician orders in the next scheduled morning stand up meeting to ensure transcription of order to the treatment record, update the CNA care plan, ensure implementation of the device, and update the comprehensive care plan. Unit managers to monitor TARs for nursing documentation and compliance that safety devices are in use every shift and night shift charge nurse to audit safety devices every night for placement and working function. Safety device training will be conducted with all new nursing hires during the orientation process.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	185160	A. BUILDING _____ B. WING _____	C 08/26/2010

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F 323	Continued From page 9 wheelchair to alert staff of unassisted transfers. Observation of Resident #2 on 08/24/10 at 11:50 AM and 12:30 PM, and 08/25/10 at 11:00 AM revealed the resident was sitting in a wheelchair; however, there was no chair alarm observed on the wheelchair. Review of the Comprehensive Plan of Care dated 08/24/10 revealed the resident was at risk for falls because of dependency on others for daily care needs. There were several interventions listed for fall prevention; however, an alarm to the wheelchair was not listed as an intervention. Interview on 08/24/10 at 10:45 AM with the MDS Coordinator revealed the Interim Care Plan was written on 07/24/10 which was the resident's day of re-admission. She stated the intervention for the chair alarm was on the Interim Care Plan; however, it had not been carried over to the Comprehensive Plan of Care. Interview on 08/25/10 at 11:00 AM with Certified Nursing Assistant (CNA) #5, revealed she was assigned to the resident on 08/24/10 and 08/25/10. She stated the aides were to refer to the "Nursing Assistants Report Sheet" which they carried in their pockets when caring for the residents. CNA #5 reviewed the Report Sheet and stated the resident was to have a chair alarm. Further interview, revealed she did not routinely check the Report Sheet when caring for the residents, and only checked it if she had a question. CNA #5 confirmed the resident did not have an alarm on the wheelchair, and also stated the resident did not have an alarm on the wheelchair on 08/24/10 while she was assigned to the resident.	F 323	4. How will the facility monitor its performance to make sure solutions are sustained? In order to monitor ongoing compliance, the Housekeeping manager or designee will conduct daily monitoring for two (2) weeks, then weekly for six (6) weeks, and then monthly for three (3) months and implement corrective actions and staff training if indicated. Housekeeping Manager will report to the monthly CQI meeting with ongoing compliance. In order to monitor ongoing compliance, unit managers will maintain a safety device log with daily updates according to changes with physician orders and resident assessment changes. The log will will be reviewed at the weekly "Standards of Care" meetings. The unit managers will monitor the treatment records for compliance in nurse documentation weekly and report to "Standards of Care". Compliance will be reported by the Director of Nursing during the monthly quality assurance (CQI) meeting. These monitoring audits of safety devices will be ongoing tools and any findings will be addressed and any corrective actions will be initiated at that time. **Completion Date 10/4/10**	

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F 323	Continued From page 10 Interview on 08/25/10 at 11:10 AM with the Unit Manager/Licensed Practical Nurse (LPN) #7, revealed she was unsure if the resident still had a Physician's Order for a chair alarm. The Unit Manager reviewed the medical record; and stated there was a current Physician's Order for an alarm to the wheelchair. Continued interview, revealed the second and third shift nurses were to check to ensure safety devices were in place daily and sign a Safety Devices Record each day to turn in; however, she had not received the Safety Devices Record for 08/24/10. Interview on 08/26/10 at 9:30 AM with the Director of Nursing (DON) revealed staff needed education related to reading the Nursing Assistant Report Sheets for safety devices. She further stated the night shift staff were to ensure safety devices were in place and operating.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 328	F 328 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality and proper treatment and care of special services per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? The tube feeding bottle and tubing was disposed of immediately on resident #2 by the unit manager when she was notified the the tube feeding was not labeled with the date and time the bottle was opened and hung, resident's name, the tube feeding rate, and the nurse's initials who hung it. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents with enteral nutrition or tube feeding methods have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. However, Resident #2 is the only resident in the facility with tube feedings.	

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F 328	Continued From page 11 review, it was determined the facility failed to ensure proper treatment and care for tube feeding services for one (1) of twelve (12) sampled residents (Resident #2). The findings include: 1. Review of Resident #2's clinical record revealed diagnoses which included Dysphagia, and Status Post Gastrostomy Tube Placement. Review of the Physician's Orders dated 08/10 revealed orders for "2 Cal HN" (tube feeding) at fifty-five (55) milliliters per hour, to run from 8:00 PM until 8:00 AM. Observation on 08/24/10 at 11:45 AM revealed a bottle of "2 Cal HN" tube feeding hanging on a tube feeding pump which was turned off. There was no indication on the tube feeding bottle of the resident's name, the date or time the bottle was opened and hung, or the tube feeding rate. Interview on 08/24/10 at 11:50 AM with the Unit Manager, revealed the tube feeding was to run for twelve hours and then the bottle and tubing were to be discarded. She further stated, the nurse who worked the previous shift should have written the resident's name, date and time the tube feeding was hung, the tube feeding rate, and the nurse's initials on the tube feeding bottle when it was hung. Further interview revealed the nurse who worked the previous shift was not a regular nurse on the unit and floated to all the units. Review of the "Enteral Nutrition Guidelines" Policy revealed there were no instructions related to labeling the tube feeding bottle prior to delivery of tube feeding.	F 328	The facility has no residents with tracheostomy needs or dialysis needs. All residents charts with respiratory needs were audited by the unit managers for accuracy by 9/13/10. Foley catheters are audited weekly by the unit managers for accuracy and reported to the weekly "Standards of Care" meetings. The facility has one resident with a prosthetic limb and one resident with a ostomy appliance and these charts were audited on 9/27/10 by the MDS nurse for accuracy. All resident charts will be audited for special care needs by medical records by 9/30/10 for accuracy in physician orders, transcription, comprehensive care plans, CNA care plans, and supporting diagnosis. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? Review of the "Enteral Nutrition Guidelines" and an addendum added to include accurate labeling of tube feeding bottles by nurses. Nursing staff in-services are scheduled for September 17th, 18th, and 23rd for review of labeling tube feeding bottles accurately with the resident's name, nurse's initials who hung it, date and time the bottle was hung, and the tube feeding rate. DON will in service nursing staff on resident special care needs and compliance with resident assessment, appropriate documentation, physician orders, diagnosis, and care plans on 9/30/10 and 10/2/10. All new nurses will be trained on policy and labeling of tube feeding and special care needs during new hire orientation. All physician orders will be placed on the 24 hour report fro 72 hours to ensure communication between shifts. MDS nurse and care plan team with audit the resident charts at the weekly scheduled care plans for accuracy in caring for resident with special care needs.	

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 431	4. How will the facility monitor its performance to make sure solutions are sustained? Unit nurse mangers or designee will monitor the tube feedings daily for accurate labeling of the bottles and document on a log sheet to be reviewed daily in morning stand up meetings for 4 weeks then at random weekly x8 weeks, then random monthly. Immediate staff education and corrective actions will be conducted if indicated during monitoring. .In order to maintain ongoing compliance, concerns will be reviewed in the weekly "Standards of Care" meeting. Compliance will be reported by the Director of Nursing during the monthly quality Assurance (CQI) meeting. Medical records will audit two (2) charts from each unit monthly for compliance and accuracy in resident special care needs to ensure physician orders are followed, transcription, appropriate diagnosis, updates to the comprehensive care plan, and CNA care plan updates. Medical records will report to DON or MDS nurse for correction if indicated promptly, and to the monthly CQI meetings. **Completion Date 10/4/10** F 431 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? No specific residents were identified as having	

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F 431	Continued From page 13 review it was determined the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles. The medication room on the Magnolia Unit refrigerator had expired Insulin vials which were open and ready for use. In addition, there were expired supplies in the medication room. Also, a treatment cart had an open tube of Triple Antibiotic ointment which was not bagged, dated or labeled. The findings include: Observation of the Magnolia Unit medication room on 08/24/10 at 3:45 PM revealed a vial of Novolog 70/30 Insulin with an open date of 07/18/10, and a vial of Novolin R Insulin with an open date of 07/21/10 in the medication refrigerator. In addition, the medication room had expired supplies which included; three (3) dressing change trays in a cabinet with expiration dates of 10/09, 01/10, and 06/10, seven (7) shielded intravenous (IV) catheters with an expiration date of 07/10, four (4) IV catheters with an expiration date of 05/10, and a box of three cubic centimeters (3 cc) syringes with an expiration date of 04/20/10. Interview on 08/24/10 at 3:45 PM with Registered Nurse (RN) #2 revealed the Insulin vials were outdated and were only good for twenty-eight (28) days after opening. She further stated she was unsure who was responsible for checking medications and supplies in the medication room for expiration dates. Interview on 08/24/10 at 4:00 PM with the Unit	F 431	2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? The expired supplies in the medication rooms, the insulins, and the ointment were disposed of immediately when identified on August 24th. All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. The facility contract pharmacist inspected all the medication rooms and carts on 8/30/10 and found no outdated medications or supplies. The unit managers inspected and cleaned the medication and treatment carts 9/3/10 and implemented any corrective action and staff education if indicated. The facility contract pharmacist reviewed and inspected the controlled medications on the medication carts and the emergency control box on 8/24/10, 8/30/10, and 9/27/10 and implemented any corrective action if indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to disposal of expired medications and supplies, proper labeling of medications, and the maintenance of medication rooms. The DON will in service nurses on the proper receiving, storage, pharmacy response to medication orders, and disposing of medications appropriately on 9/30/10 and 10/2/10. All new nurses will be in-serviced on disposal of expired medications and supplies, proper medication labeling, and maintaining clean, organized medication rooms, receiving, storage, medication orders, and disposing of medications appropriately during the new hire orientation process.	

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F 431	Continued From page 14 Manager/Licensed Practical Nurse (LPN) #7, revealed she was unsure who was responsible for checking for expired items in the medication room. Interview on 08/26/10 at 9:30 AM with the Director of Nursing revealed she was aware the medication rooms were "cluttered and disorganized" and she had plans for the night shift Supervisor to be in charge of the medication rooms. However, at that time, the Unit Managers were responsible for checking for expired medications and supplies in the medication rooms. Review of the facility's policy, "Equipment and Supplies for Administering Medications", revealed the charge nurse on duty ensured equipment and supplies relating to medication administration were clean and orderly, and the consultant pharmacist monitored medication storage conditions. Review of the facility's policy, "Recommended Expiration Dates", revealed Novolog 70/30 Insulin should be discarded twenty-eight (28) days after opening, and Novolin R Insulin should be discarded thirty (30) days after opening. 2. Observation of the Unit 1 treatment cart on 08/24/10 at 4:00 PM revealed an open tube of Triple Antibiotic ointment that appeared to be half full. The ointment was not bagged, dated or labeled. Upon discovering the tube, Licensed Practical Nurse (LPN) #2 discarded it in the trash. The LPN stated, "that shouldn't be there." Interview with the Unit Manager on 08/24/10 at	F 431	Pharmacist or designee will conduct monthly medication room inspections, medication and treatment cart inspections for 3 months on all units then once a quarter if standards are met. Any findings will be addressed and any necessary corrective actions will be initiated at that time. Pharmacy provided a new updated information sheet "Recommended Expiration Dates" for appropriate disposal times for medications. These were placed in the front of all medication administration books (MARs) and treatment books (TARs) located on the medication carts and posted in the medication rooms on September 1st and will be reviewed at the scheduled nursing meetings on September 17th, 18th, and 23rd. 4. How will the facility monitor its performance to make sure solutions are sustained? Unit managers will monitor medication rooms and medication and treatment carts weekly with any findings being addressed and any corrective actions initiated at that time. The night shift charge nurses are responsible for cleaning and organizing the medication rooms once weekly and as needed, with monitoring by the unit managers. Unit Managers are to report concerns to the DON and to the weekly "Standards of Care" meeting. The DON will report to the monthly CQI. This will be an ongoing monitoring and reporting to ensure compliance. The facility contract pharmacist will report to the DON or designee during any visit to the facility of her inspection findings or any concerns noted, and she will report her monthly inspections and actions implemented monthly to the CQI meetings.	Completion Date 10/4/10

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F 431	Continued From page 15 4:05 PM revealed no unlabeled medications should have been stored on the treatment cart.	F 431	F 441	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? No specific resident was identified as having been affected by the alleged deficient practice. The KMA #2 and on the CNA #5 was in-serviced on August 26, 2010 by the DON of hand washing, use of hand sanitizer and infection control guidelines. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. The DON reviewed the resident inspection Control logs for the past thirty days and found Facility outbreaks of infectious diseases on 10/1/10. Resident infections are tracked, logged daily by the unit managers and discussed in the morning stand up meetings and reported weekly to the Don in the "Standards of Care" meetings. The DON or designee monitors the infection control program (ICP). The ICP consists of surveillance, data collection, detection, investigation, management, antibiotic review, isolation precautions, education, exposure	

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, and sanitary environment to help prevent the development and transmission of disease and infection. The findings include: Review of the facility's, "Handwashing" Policy revealed handwashing was the most important component for preventing the spread of infection. The Policy further stated, handwashing should be performed when hands were visibly soiled, before and after resident contact, after contact with soiled or contaminated articles, such as articles that were contaminated with body fluids, and after removal of medical/surgical or utility gloves 1. Observation of the medication pass on 08/25/10 at 8:30 AM revealed Kentucky Medication Assistant (KMA) #2 administered medications to unsampled Resident #1 with a spoon and assisted the resident to sip from a cup of water. KMA #2 then began to set up medications for the next resident. There was no evidence she washed or sanitized her hands after administering medication to unsampled Resident #1 and prior to beginning to set up medications for the next resident. Interview with KMA #2 on 08/25/10 at 8:35 AM revealed she usually sanitized her hands after administration of medication. Observation	F 441	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? All nursing staff was instructed on hand washing, use of hand sanitizer, review of the hand washing policy, and each employee performed a return hand washing demonstration on September 10th 11th, by the staff development nurse and her designees. All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to hand washing, use of hand sanitizer, infection control prevention and guidelines. All new hires will be in-serviced on hand washing, use of hand sanitizer, infection control prevention, and guidelines during the the orientation process. Education on infection control guidelines will be conducted twice yearly by the staff development nurse or DON. The nursing team monitors the infection control logs and new physician orders daily in the morning Stand up meetings. The DON or designee monitors the infection Control program weekly during the "Standards of Care".	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	700 MASON HEADLEY ROAD LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 revealed she had a bottle of sanitizer on top of the medication cart. 2. Observation of perineal care on 08/25/10 at 9:20 AM, revealed Certified Nursing Assistant (CNA) #5 wiped stool from the resident's anal area, removed the soiled gloves, and opened the door to the hall. CNA #5 came back in the resident's room carrying bed linens. There was no evidence CNA #5 washed her hands after removing the soiled gloves and prior to leaving the room to obtain items from the linen cart. Interview with CNA #5 on 08/25/10 at 9:30 AM revealed she removed her soiled gloves and did not wash her hands after performing perineal care. Further interview revealed she should have washed her hands to prevent contamination. Interview on 08/26/10 at 9:30 AM with the Director of Nursing (DON)revealed staff should sanitize their hands between residents during medication pass. Further interview revealed handwashing should be done after the removal of gloves. Continued interview, revealed she needed to have a handwashing inservice.	F 441	4. How will the facility monitor its performance to make sure solutions are sustained? The unit managers and house nurse supervisors will monitor two (2) staff members with Hand washing during resident care and use of Hand washing or hand sanitizer during medication pass times and observe infection control precautions every shift for two (2) weeks, then every shift weekly for six (6) weeks, and then every shift monthly for three (3) months. Unit Managers will report weekly to "Standards of Care" meetings any compliance concerns. Unit managers will address any findings and initiate any corrective actions at that time. Pharmacy will observe two (2) staff medication passes monthly for hand washing compliance for three (3) months and will initiate any corrective action at that time, and will report to the monthly CQI meeting. Compliance will be reported by the Director of Nursing during the monthly quality assurance (CQI) meeting. The infection control program monitoring will be reported by the DON in the monthly CQI meetings.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	**Completion Date 10/4/10**	

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F 514	Continued From page 18 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure clinical records were maintained on each resident in accordance with accepted professional standards and practices. The findings include: Review of Resident #12's closed record revealed diagnoses which included Dementia and Cerebrovascular Accident (CVA) with Hemiplegia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/23/10 revealed the facility assessed the resident as having both short and long term memory loss, as requiring extensive to total assistance with Activities of Daily Living, and as sustaining a fall within the last thirty (30) days. Review of an Incident Report revealed the resident sustained a fall on 02/11/10 at 10:00 AM and was found on the floor beside the bed on his/her knees with no injuries noted. Further review of the Report revealed the Responsible Party was notified on 02/11/10 at 2:00 PM. The section of the Report which stated, "Was it necessary to notify the Physician ?" had N/A (not applicable) written in by Licensed Practical Nurse (LPN) #11. Further review of the record revealed there was no Nurse's Note written related to the fall on 02/11/10 at 10:00 AM.	F 514	F 514 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? Resident #12 was identified as having been affected by the alleged deficient practice of maintaining clinical records for each resident that are complete, accurately documented, readily accessible, and systematically organized; however Resident #12 is no longer a resident in our facility and this review was a closed record. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents having an event that deems the completion of an incident report have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. Medical Records audits five (5) active resident charts from each unit for compliance that the clinical records were complete, had accurate documentation, were readily accessible, and organized by 9/23/10. Any findings were addressed and any corrective actions were completed at that time.	

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F 514	Continued From page 19 Review of another Incident Report revealed the resident sustained a fall on 02/11/10 at 1:40 PM and was found lying on the floor beside the bed with no injuries noted. Further review of the Report revealed the Responsible Party was notified on 02/11/10 at 2:10 PM. The section of the report which stated, "Was it necessary to notify the Physician ?" had N/A (not applicable) written in by Licensed Practical Nurse (LPN) #11. Review of the Nurse's Notes dated 02/11/10 at 2:00 PM did not indicate if the Physician was notified of the fall. Interview on 08/26/10 at 4:00 PM with LPN #11 revealed she no longer worked at the facility and she felt overwhelmed and did not have enough training while working at the facility. Further interview revealed she knew to notify the Physician after a fall and had notified the Nurse Practitioner who was on the unit verbally of the falls on 02/11/10. She further stated, she should have documented on the Incident Report or on the Nurse's Notes indicating the Nurse Practitioner or Physician was notified. Further interview revealed she assessed the resident after the falls and completed the Incident Reports. She stated she thought she had documented her assessment of the fall on the Nurse's Notes related to the fall on 02/11/10 at 10:00 AM. Attempts were made to reach the Nurse Practitioner; however she was unable to be reached. Interview on 08/26/10 at 3:30 PM with the Director of Health Services/ Corporate Administrator revealed she was in the facility daily during the time period of the resident's falls. She stated the	F 514	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted by the Director of Nursing related to the appropriate documentation required for a resident event and completion of an incident report to maintain a complete, accurate, accessible, and organized resident record. All new hire nursing staff will be in-serviced on the resident clinical record during the orientation process. All incident reports will be review by the nursing interdisciplinary team in the next day morning stand up meeting. The resident's record or chart will be brought to the stand up meeting and will be compared to and reviewed with the incident report to ensure proper notification of family and physician, accurate completion of the incident report, update to the resident care plan, an appropriate resident assessment was completed and a nursing narrative documentation was completed. Any findings will be addressed and any necessary corrective actions will be initiated at that time. The MDS nurse and care plan team will audit the resident charts scheduled for that week's care plan meetings for maintaining a complete and accurate clinical record. Any findings will be addressed and any corrective actions will be initiated at that time.	

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F 514	Continued From page 20 nurses were to notify the Physician of any fall regardless f there was an injury and this should be specified on the Incident Report. She further stated the nurses were to complete a Nurse's Notes with an assessment of the resident after a fall. Interview on 08/26/10 at 3:40 PM with the Director of Nursing (DON) revealed she did not work at the facility in 02/10 at the time of the resident's falls. She further stated the Physician should be notified of any fall, and the Fall Incident Report as well as a Nurse's Note should be completed after a fall. She stated the facility was unable to locate a Nurse's Note related to the fall on 02/11/10 at 10:00 AM.	F 514	4. How will the facility monitor its performance to make sure solutions are sustained? Ongoing compliance will be consist of the Incident report and resident record review Completed daily in the scheduled morning Stand up meetings as stated in the above #3 Corrective action plan. Medical records will audit two (2) charts from each unit monthly for compliance with maintaining complete and accurate clinical records that are accessible and organized and will report findings to the DON or MDS nurse promptly if a correction is needed and will report monthly to the CQI team and will continue this audit as determined by the CQI team.. Compliance with this review will be reported by the Director of Nursing during the monthly quality assurance (CQI) meeting. **Completion Date 10/4/10**	

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/25/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was a "D".	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure doors located in the corridor could resist the passage of smoke according to NFPA standards.	K 018	K 018 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to maintain Compliance with NFPA 101 Life Safety (2000 ed.) requirements/regulations. (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? No specific residents were identified as having been affected by the alleged deficient practice. 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below.	

RECEIVED
SEP 28 2010
BY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Staiano RN DON	DON	9-17-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Amendment: Angela Staiano RN DON 9-27-10

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K 018	Continued From page 1 The findings include: Observation on 08/25/2010 at 11:30 PM, revealed the resident's room door, in room number 116, was unable to resist the passage of smoke, due to a gap, of approximately ½ inch, which was located at the top right section of the door. The observation was confirmed with the Director of Maintenance, at that time. Interview on 08/25/2010 at 11:30 PM, with the Director of Maintenance, revealed he was unaware of the door having a gap which would allow smoke to enter the room in the event of a fire. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not	K 018	3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? The resident room door #116 was repaired by squaring the door and eliminating the gap, to correct the space located at the top right section of the door. The repair was completed on August 25, 2010. All doors were inspected to assure proper closure with no space/gaps present on August 25, 2010. 4. How will the facility monitor its performance to make sure solutions are sustained? Ongoing compliance will be consist of all door checked by maintenance staff monthly during Life Safety inspections and scheduled Fire Drills. Any findings will be addressed and any necessary corrective actions will be initiated at that time. Compliance will be reported by the Maintenance Director or Administrator during the monthly quality assurance (CQI) meeting. **Completion Date 8/31/10**	

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K 018	Continued From page 2 contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintain according to NFPA standards. The findings include: Observation on 08/25/2010 at 1:36 PM, revealed one (1) sprinkler head in the kitchen area was found to be positioned to far into the ceiling to produce an effective spray pattern in the event of a fire. Further observation, of the conference room, revealed an escutcheon plate for one (1) sprinkler that had fallen down blocking the sprinkler head. The observations were confirmed with the Maintenance Director, at that time.	K 062	K 062 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to maintain Compliance with NFPA 101 Life Safety (2000 ed.) requirements/regulations. (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? No specific residents were identified as having been affected by the alleged deficient practice.	

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K 062	Continued From page 3 Interview on 08/25/2010 at 1:36 PM, revealed the Maintenance Director was unaware of the two (2) sprinkler heads being obstructed. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces	K 062	2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? The one (1) sprinkler head located in the kitchen area was repaired to the accurate position to produce an effective spray pattern by Simplex Grinnell on August 30,2010. The escutcheon plate on one (1) sprinkler located in the conference room was repaired to the proper position not to block the sprinkler head by maintenance on August 25, 2010. All sprinklers were inspected on August 25, 2010. 4. How will the facility monitor its performance to make sure solutions are sustained? Ongoing compliance will be consist of scheduled quarterly sprinkler inspections by Simplex Grinnell and by Maintenance staff during monthly Life Safety inspections. Any findings will be addressed and any necessary corrective actions will be initiated at that time. Compliance will be reported by the Maintenance Director or Administrator during the monthly quality assurance (CQI) meeting. **Completion Date 8/31/10**	

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K 062	Continued From page 4 such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wall fixtures inside oxygen storage rooms were protected according to NFPA standards. The findings include: Observation on 08/25/2010 at 11:38 AM, revealed that inside the oxygen storage room located on the Station One Wing, there were two (2) electrical wall fixtures located approximately two (2) feet high mounted on the wall. Electrical wall fixtures must be located a minimum of five (5)	K 076	K 076 This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. It is the policy of Five Star Quality Care (Lexington Country Place) to maintain Compliance with NFPA 101 Life Safety (2000 ed.) requirements/regulations. (see attachment). 1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice? No specific residents were identified as having been affected by the alleged deficient practice.	

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K 076	Continued From page 5 feet from the surface of the floor in oxygen supply rooms to prevent damage to the electrical wall fixtures. The observation was confirmed with the Maintenance Director, at that time. Interview on 08/26/2010 at 11:38 AM, with the Maintenance Director, revealed he was unaware that electrical wall fixtures must be mounted a minimum of five (5) feet from the level of the floor in oxygen supply rooms. Reference: NFPA 99 (1999 edition) 4-3.1.1.2 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.	K 076	2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice? All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not reoccur? The two (2) electrical wall fixtures were repaired by raising both to the minimum wall height of five (5) feet from the surface of the floor in the oxygen storage room located on Station One (1). The repair was completed by maintenance on August 25, 2010. There are no other oxygen storage rooms in the facility to inspect. 4. How will the facility monitor its performance to make sure solutions are sustained? Ongoing compliance will be consist of monthly inspection of the oxygen storage room for safety checks by maintenance staff during Life Safety inspections. Any findings will be addressed and any necessary corrective actions will be initiated at that time. Compliance will be reported by the Maintenance Director or Administrator during the monthly quality assurance (CQI) meeting. **Completion Date 8/31/10**	